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Placement Challenges Persist for Child Victims of Commercial Sexual Exploitation; Questions Regarding Effective Interventions and Outcomes Remain

at a glance

A total of 264 verified commercial sexual exploitation child victims (CSE children) were identified in calendar year 2015, more than the 170 identified from July 2013 through December 2014. CSE children are to be placed and served in specialized residential programs, such as safe houses and safe foster homes. However, there are a limited number of these beds and provider criteria exclude some children. Providers report that they deliver consistent statutorily-required services to children, and the Department of Children and Families (DCF) is conducting a review of literature to identify effective interventions for CSE children.

Many CSE children we identified in our previous report had since been re-victimized, involved with the criminal justice system, or only attended school intermittently.

State agencies, including DCF and the Department of Juvenile Justice (DJJ), continue working to better identify CSE children through community awareness, training, better information system tracking, and a new screening tool. The Human Trafficking Screening Tool has been released for

use but concerns exist; DCF and DJJ should prioritize getting feedback on the screening tool and validating it.

Scope

Chapter 2014-161, *Laws of Florida*, directs OPPAGA to conduct an annual study on commercial sexual exploitation (CSE) of children in Florida. We issued our initial report in June 2015.¹ This review reports on the number of children that the Department of Children and Families identified and tracked as victims of CSE; describes residential options and specialized services provided to children; and presents short-term social outcomes for children identified in the 2015 report.

Background

Human trafficking takes several forms including commercial sexual exploitation

Human trafficking is the exploitation of another human being through fraud, force, or coercion.² Both federal and Florida law criminalize human trafficking of adults and children. Victims of human trafficking are subjected to commercial sexual exploitation (CSE) and/or forced labor.³

¹ *State and Local Agencies Are in Initial Stages of Addressing Needs of Child Victims of Commercial Sexual Exploitation*, OPPAGA Report No. 15-06, July 2015.

² Section 787.06, F.S.

³ Labor trafficking includes debt labor, bonded labor, and forced labor.

Federal and state law define CSE (also referred to as sex trafficking) to be any commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform such act is a minor.⁴ CSE includes exchanging any sex act for anything of value and includes prostitution, stripping, and pornography. In 2015, the National Human Trafficking Resource Center reported receiving information on approximately 4,136 cases nationwide pertaining to sex trafficking; of these, 1,379 cases were related to minors.

Recent statutory changes further protect CSE children. To serve the needs of children who become CSE victims, the Legislature passed the Florida Safe Harbor Act of 2012, which, among other issues, focuses on rescuing and protecting sexually exploited minors, and providing specialized treatment and services, including residential settings referred to as safe houses. In 2014, the Legislature enhanced services for CSE children through Ch. 2014-161, *Laws of Florida*, further specifying the roles of state agencies and service providers in serving this population. The 2016 Legislature, in Ch. 016-24, *Laws of Florida*, protects children from being arrested and prosecuted for prostitution. The law also revises the definition of the term “sexual abuse of a child,” to delete references to prostitution offenses. This change is intended to ensure that children are viewed as victims, not offenders, in matters involving prostitution.

State, local, and federal entities have responsibilities in investigating child CSE and helping victims

Both state and local entities engage in activities to combat CSE in Florida. The Department of Children and Families (DCF) is responsible for the child welfare needs of CSE children.⁵ Generally, if an allegation of human trafficking is verified, DCF will make either a judicial or non-judicial intervention, depending on the circumstances of

the exploitation.⁶ In a non-judicial intervention, the child stays in her or his home and receives a non-judicial case plan and referral for services. With a judicial intervention, the child is adjudicated dependent and receives either an in-home judicial case plan or an out-of-home placement.⁷

DCF contracts with community-based care lead agencies in 20 circuits across the state to manage child welfare services, including services for CSE children who are adjudicated dependent or whose cases are still being investigated. The lead agencies subcontract with providers for services including case management, emergency shelter, foster care, and other out-of-home placements in all 67 counties.

The Department of Juvenile Justice (DJJ) partners with DCF to identify CSE children who are brought into the delinquency system and to divert them to the child welfare system when appropriate. At delinquency intake, DJJ staff assesses all children and conducts further screening of any child who demonstrates indicators related to sexual exploitation. When appropriate, DJJ contacts the Florida Abuse Hotline.

Local sheriffs’ offices and police departments also investigate cases involving CSE children. Some local law enforcement offices designate specific staff to conduct these investigations. In addition, some local law enforcement agencies also participate in regional human trafficking task forces.

The Department of Legal Affairs, Office of the Attorney General prosecutes persons charged with trafficking children and administers services and grants that may aid CSE children. For example, the Attorney General’s Division of Victims of Crime administers crime victim compensation and grants to child protection teams across the state. Further, as directed by Ch. 2014-161, *Laws of Florida*, the Attorney General

⁴ 22 USC 7102 and Ch. [2012-105](#), *Laws of Florida*.

⁵ For information on DCF’s hotline intake and child protective investigation process, see Appendix A.

⁶ Specifically, a verified finding of CSE would result in a needs assessment, a multidisciplinary Safe Harbor staffing, and possible referral to services.

⁷ In the case of CSE children, s. 39.01 (15)(g), *F.S.*, defines dependent to mean to have been sexually exploited and to have no parent, legal custodian, or responsible adult relative currently known and capable of providing the necessary and appropriate supervision and care.

created and currently chairs the Statewide Council on Human Trafficking. The council's duties include developing recommendations for programs and services, making recommendations for apprehending and prosecuting traffickers, and developing overall policy recommendations.

Lead agencies spent more caring for CSE children than provided in agency budget allocations

For Fiscal Year 2014-15, lead agencies expended about one-third more than their allocated budget for CSE children's services, i.e., expenditures totaled \$3.9 million with a budget allocation of \$3 million. For the majority of lead agencies, expenditures when compared with budgets ranged from 100% to 954%, indicating that lead agencies expended other child welfare funds to serve CSE children. Only three lead agencies had unexpended budget for CSE children's services at the end of the budget year. (See Exhibit 1.)

Exhibit 1

Lead Agencies Expended 133% of Their Budget Allocation for Fiscal Year 2014-15

Lead Agency	Counties Served by Lead Agency ¹	CSE Budget Allocation	Total Expenditures of Fiscal Year 2014-15 Funds	Percentage of Budget Expended
Big Bend Community-Based Care	Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla, Bay, Calhoun, Gulf, Holmes, Jackson, Washington	\$61,224	\$74,974	122%
ChildNet	Broward	\$505,102	\$688,742	136%
ChildNet	Palm Beach	\$306,122	\$332,227	109%
Children's Network of Southwest Florida	Charlotte, Collier, Glades, Hendry, Lee	\$107,143	\$127,718	119%
Community Partnership for Children	Flagler, Putnam, Volusia	\$15,306	\$8,002	52%
Brevard Family Partnership	Brevard	\$30,612	\$130,447	426%
Community-Based Care of Central Florida	Orange, Osceola	\$183,673	\$239,279	130%
Community-Based Care of Central Florida	Seminole	\$15,306	\$90,212	589%
Devereux Community-Based Care	Indian River, Martin, Okeechobee, St. Lucie	\$61,225	\$63,146	203%
Eckerd Community Alternatives	Hillsborough	\$187,856	\$164,064	87%
Eckerd Community Alternatives	Pasco, Pinellas	\$210,104	\$304,860	145%
Families First Network	Escambia, Okaloosa, Santa Rosa, Walton	\$15,306	\$7,150	47%
Family Support Services of North Florida	Duval, Nassau	\$76,531	\$76,531	100%
Heartland of Children	Hardee, Highlands, Polk	\$183,673	\$212,005	115%
Kids Central	Citrus, Hernando, Lake, Marion, Sumter	\$61,225	\$135,658	222%
Kids First of Florida	Clay	-	-	-
Our Kids	Miami Dade, Monroe	\$841,837	\$842,441	100%
Partnership for Strong Families	Alachua, Baker, Bradford, Gilchrist, Levy, Union, Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor	\$61,224	\$253,282	414%
Sarasota Family YMCA	DeSoto, Manatee, Sarasota	\$61,225	\$93,276	152%
St. Johns County Board of County Commissioners	St. Johns	\$15,306	\$146,994 ²	954%
Total		\$3,000,000	\$3,990,107	133%

¹ Not all counties in a lead agency's service area have verified cases of CSE children.

² Includes \$131,088 in funds carried forward.

Source: OPPAGA analysis of Department of Children and Families data.

As shown in Exhibit 2, eight providers accounted for 74% of expenditures for children's services. Further, we observed that three residential treatment providers offer specialized mental health and/or substance abuse treatment programs and accounted for 53% of expenditures for CSE children's services. Seventeen percent of payments went to designated safe houses, one of which is no longer in operation. The remaining 4% of payments went to a group care provider that is not a designated safe house but provides services to CSE children.

Exhibit 2

Eight Providers Received Most of the Funding for CSE Children's Services in Fiscal Year 2014-15

Provider	Total Payment Amount	Percent of Total Payments Statewide	Total CSE Children Served	Daily Rate
Residential Treatment Providers				
1	\$1,303,703	33%	26	\$432
2	695,252	17%	90	\$138
3	114,284	3%	4	\$223-\$250
Safe House Providers				
1	226,825	6%	17	\$300-\$325
2	224,755	6%	5	\$225-\$245
3	114,367	3%	13	\$308
4	102,837	3%	12	\$240-\$300
Group Care Provider				
1	166,050	4%	3	\$248-\$283
Total	\$2,948,073¹	74%	170²	Average Daily Rate=\$271

¹ Remaining payments to other providers for services to CSE children equaled \$697,079, and payments to all providers for services to CSE children totaled \$3,645,152. The difference of \$344,955 between this figure and the total lead agency expenditures shown in Exhibit 1 is due to cash versus accrual reporting methods.

² The total of 170 CSE children served includes some from the June 2013 through December 2014 population included in the 2015 OPPAGA report, as well as some served in calendar year 2015 in the current study.

Source: OPPAGA analysis of Department of Children and Families data.

2014-15 daily rates for CSE children's services vary by provider and provider type. For Fiscal Year 2014-15, daily rates for comprehensive mental health and substance abuse services ranged from \$223 to \$432. For the same period,

providers of specialized therapeutic foster homes had a daily rate of \$138. In contrast, safe house daily rates ranged from \$225 to \$325. Providers report that in addition to the daily bed rate paid by lead agencies, they receive funding from a range of sources, including fundraising events to cover operating costs and soliciting and receiving in-kind donations, such as health care and food. In Fiscal Year 2015-16, DCF also distributed \$3 million to serve CSE children. In addition, the Legislature appropriated \$5.3 million to six entities for various CSE special projects.⁸

Prevalence

Higher Number of Verified CSE Children in Calendar Year 2015

Experts agree that obtaining an accurate count of CSE children is challenging because CSE victims are not readily identifiable. CSE victims do not have immediately recognizable characteristics, many do not have identification, and they are often physically and/or psychologically controlled by adult traffickers. Child protective investigators (CPIs) we interviewed said that these cases are particularly difficult to investigate because CSE children rarely disclose or provide information on exploitation. CSE children also can be difficult to locate due to a high rate of runaway episodes.

For calendar year 2015, DCF verified 264 child victims of commercial sexual exploitation. To estimate the number of allegations and subsequently verified CSE cases, we relied on DCF's Florida Safe Families Network (FSFN) data on hotline intakes and child protective investigations during calendar year (CY) 2015.⁹

The number of verified CSE cases increased from 170 for the period July 2013 through December 2014 to 264 in CY 2015. The higher number of verified cases in CY 2015 could have resulted from improvements in DCF data quality, improved surveillance, and/or

⁸ The Legislature also appropriated \$1.5 million to providers that serve adult victims of CSE.

⁹ FSFN is the data system for DCF's Office of Child Welfare Operations.

increased public awareness, rather than an increase in human trafficking victims.¹⁰

During CY 2015, the Florida Abuse Hotline, operated by DCF, received a total of 1,279 reports alleging the CSE of children; CPIs investigated 889 (or 70%) of those reports.^{11, 12} Counties with the highest numbers of reports include Broward (144), Miami-Dade (141), and Pinellas (100). DCF hotline staff did not refer cases for investigation if the allegation did not rise to the level of reasonable (72%), there were no means to locate the victim (11%), or the alleged perpetrator was not the child's caregiver (10%).¹³ Of the reports that were referred for investigation, most came from DJJ, the Department of Corrections, or criminal justice personnel (19%) and law enforcement (18%).

The investigations resulted in the verification of 264 child CSE victims. Twenty-two victims were verified in more than one investigation. The counties with the highest numbers of verified victims included Miami-Dade (45), Hillsborough (33), Broward (26), and Orange (24). (See Appendix B for verified victims by county.) From our original 2013-14 cohort of victims, 22 of the 170 victims had verified CSE allegations again in 2015.

The 2015 cohort of 264 verified victims share similar demographic characteristics with the CSE victims identified in our prior report; 92% were age 14 or older, and one-third were 17; 93% were females; and 51% were white. At the time of the DCF investigation, 71 verified CSE children were in out-of-home care, including the care of relatives or in foster homes, residential group care, or residential treatment

centers. For an in-depth profile of the social characteristics of CSE children, see Appendix C.

Placement

Placement of CSE children in designated safe houses and safe foster homes remains a problem for lead agencies

Florida statutes require that for verified CSE victims, lead agencies must assess every dependent child six years of age or older for placement in a safe house or safe foster home. Safe houses and safe foster homes are required to provide a safe, separate, and therapeutic environment tailored to the needs of sexually exploited children who have endured significant trauma.¹⁴ If placement in a safe house or safe foster home is determined to be appropriate, the child may be placed in these settings if available. Children may be placed in another setting, such as residential group care or residential treatment centers, if these are more appropriate for the child's needs, or if a safe house or safe foster home is not available. A total of 141 CSE children were not involved in the child welfare system beyond their investigation; these children have no placements or CSE services. (See Appendix D for an overview of the placement process and

¹⁰ The count of verified CSE children for CY 2015 should be reasonably complete because DCF addressed data issues by July 2015. In addition, for cases that were verified from January through June 2015 that used the old allegation codes, DCF staff manually identified additional children.

¹¹ Calendar Year 2015 data for reports made to the hotline (1,279) and investigations (889) are incomplete because of changes in how the hotline staff used DCF's maltreatment codes. We have greater confidence in the 264 total verified CSE cases because DCF staff conducted a manual review of case files due to issues with the maltreatment codes.

¹² Of the 1,279 reports received, the hotline staff accepted 1,004 reports for investigation, while 115 were closed for jurisdictional

reasons, including that the child lived out of the state or was over 18 years old.

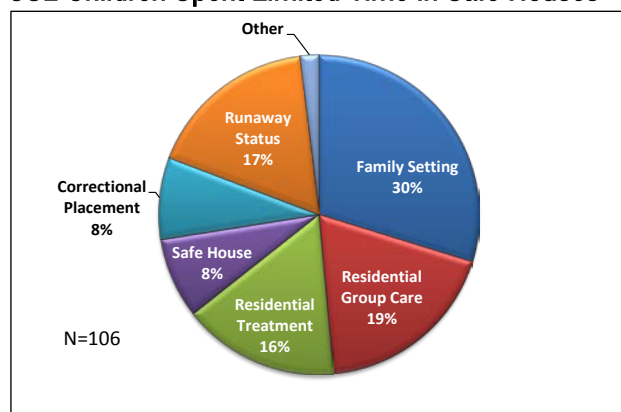
¹³ The 10% of cases screened out based on caregiver status were screened out in error. For typical child welfare cases, the caregiver must be the alleged perpetrator for the report to be referred for a child protective investigation. DCF recently updated its operating procedures to specify that hotline staff should no longer screen out reports alleging CSE where the alleged perpetrator is not a caregiver.

¹⁴ As specified in s. 409.175, *F.S.*, a safe foster home is a licensed family foster home, and a safe house is a licensed residential child-caring agency providing staffed 24-hour care for children.

the range of placements available to CSE children.)^{15, 16}

Most of CSE children's time in care after their CSE investigation was not in a safe house. For the 264 verified CSE cases in CY 2015, we identified 106 dependent children that spent time in out-of-home care after their CSE investigation. Exhibit 3 shows the total percentage of time in placements for the 106 children receiving out-of-home services.¹⁷ When looking at those placements, 8% of the total time in care was in safe house placements and 30% of the time was spent in a family setting, which includes foster homes.¹⁸ An additional 17 dependent CSE children had only in-home placements after their CSE investigation

Exhibit 3
CSE Children Spent Limited Time in Safe Houses



¹ Other includes hospital placements and visitation.

² Family setting includes traditional foster homes, specialized therapeutic foster homes, and relative and non-relative placements.

Source: OPPAGA analysis of Department of Children and Families data.

Complex mental health and substance abuse needs mean that some traditional child welfare programs and CSE placements may not be appropriate for CSE children. According to lead agencies, CSE children's mental health and substance abuse needs outweigh their CSE needs initially, so voluntary or involuntary placement in treatment facilities is more appropriate than a safe house or safe foster home. Lead agency staff also reported that many CSE children had histories of placement in family foster care or group home care and had behaviors that led to disruptions of such placements.

In a sample of case files we reviewed, we found that the majority of CSE children had one or more diagnosed mental health disorders, such as depression, bipolar or other mood disorders, conduct disorder, oppositional defiant disorder, Attention Deficit Hyperactivity Disorder, generalized anxiety disorder, and Post-Traumatic Stress Disorder (PTSD).¹⁹ CSE children also admitted to or had evidence of substance misuse including alcohol, cannabis, and narcotics, often in addition to their mental health disorders. Moreover, case files showed that many children had active mental health or substance abuse issues at the time of the investigation that were significant enough to warrant temporary placement in mental health units (crisis stabilization units or hospital inpatient units) or substance abuse detoxification programs for stabilization, sometimes followed by placements in longer-term treatment programs.

Safe houses and safe foster homes serve only a small number of CSE children. **Limited**

¹⁵ Residential group care is a type of residential child-caring agency as specified in s. 409.175, *F.S.*, which provides staffed 24-hour care for children. Residential treatment centers are 24-hour residential programs that provide mental health treatment and services to emotionally disturbed and seriously emotionally disturbed children as specified in ss. 394.495(4)(j) and 394.875(1)(c), *F.S.* Placements in residential treatment centers require a suitability assessment by a qualified evaluator appointed by the Agency for Health Care Administration and an ongoing review of the child's progress by the qualified evaluator and the court having jurisdiction over the child. See Appendix D for more information on placements.

¹⁶ Sections 39.524 and 409.1754(1), *F.S.*

¹⁷ To calculate percentage of time, we totaled time spent in every placement for all children from the CSE investigation intake date to the end of either the removal episode closest to the CSE investigation or the end of our follow-up study period (March 12, 2016).

¹⁸ Of the 106 CSE victims served in out-of-home care, 22 children were placed in a safe house after their investigation for CSE was received. The calculation of time spent in residential settings does not include the Other category presented in Exhibit 3.

¹⁹ For our case file review, we selected a random proportional sample of children receiving services who had a verified finding of CSE between July 2013 and December 2014. This sample may not be representative of children who did not receive services.

placements in safe houses and safe foster homes are related, in part, to availability. There are four designated safe houses offering 24 beds for children needing care. One provider operates 15 specialized therapeutic foster care homes for CSE children in Miami-Dade, with most accommodating a single child. Another provider funded to recruit and train safe foster families has established one safe foster home in the Southeast region of the state. Lead agencies reported that efforts to recruit safe foster families have not been successful. Lastly, there are residential treatment centers in Osceola and Brevard counties that provide CSE treatment tracks within their larger existing programs.

Further, lead agency administrators in regions with high prevalence for CSE also stated they preferred to keep children in the area, if at all possible, to maintain continuity in case management and treatment services. However, statewide, only two DCF regions (Central and SunCoast) offer designated safe houses and residential treatment programs for CSE children. As a result, many lead agencies do not have a safe house or other CSE children's programs in their geographic area.

Provider criteria also may limit availability. CSE safe house providers set criteria for the children they serve; however, some providers may exclude children based on characteristics that are typical of CSE children. Most safe houses will not accept

- pregnant girls or will not keep girls beyond the first trimester of pregnancy;
- children who have custody of biological children;
- children with mental health issues not controlled by psychotropic medication;
- children whose active substance use would require detox services; and
- children that are physically aggressive or violent.

Our case file review of 24 CSE children's cases found that most children have one or more of these conditions, which would exclude them from safe houses. For example, most children

had diagnosed mental health disorders, and several refused to take or inconsistently take medication for mental health conditions. Many children also were actively using illegal substances.

Provider acceptance of children with certain other characteristics varies among safe house providers. For example, one provider will not accept children with intellectual disabilities, and will not accept children back into the program after a runaway episode. Our review of case files found that several children had intellectual disabilities and the majority of children had histories of runaway behavior from parents or out-home-placements.

Some designated safe houses also require a discussion with the child before admission into the program is approved. Lead agency staff report that safe houses only accept children who see themselves as victims and want to change their behavior; however, they also noted that the problem with that approach is that CSE children generally do not see themselves as victims and do not see their behavior as inappropriate. Our review of CSE children's FSFN case files support this—the children did not see themselves as engaging in destructive or inappropriate behavior, did not acknowledge accepting money in exchange for sex or saw nothing wrong with this, and often saw the alleged perpetrator as a boyfriend.

Moreover, placement in a safe house is voluntary for CSE children. Lead agencies reported that some children, on hearing the safe house restrictions, refuse to go to the program. For example, children may not be allowed to have cell phones or access to other electronic devices while in the program. In addition, safe houses may not use traditional public schools for their educational component, and children may find the alternative forms of education too restrictive and refuse to enter the program. Our review of CSE children's case files found that most of children had a history of school truancy, poor academic performance, and placements in alternative or special education programs or schools.

In general, CSE safe house provider admission criteria present placement issues for lead agencies. Lead agency staff serving CSE children reported that few other placements accept CSE children due to behavior issues and concerns for other children in care.

Placements for CSE children are further complicated by the lack of emergency shelters. Emergency shelters are an important initial placement for all children (including CSE children) removed from their homes, e.g., for children who have no responsible adult able to provide care for them, or for children who are experiencing placement disruptions.²⁰ However, safe houses and other types of residential care are not designed to be emergency placements due to admission processes, the limited number beds, and bed availability.

Lead agency staff, CPIs, and case managers expressed two concerns about CSE children needing emergency shelter. First, the lack of emergency placements for CSE children can result in investigators and case managers staying with CSE children after hours until a placement can be found. Second, traditional emergency shelters that typically serve other child populations may not be appropriate for CSE child victims. The propensity of CSE children to run from placements combined with the risk that they might recruit other children to run with them further complicates emergency placements.

Services

Residential providers report a similar service array for CSE children; less

certainty exists about services for children in the community

In contrast to our 2015 findings, residential providers reported providing a similar array of services for CSE child victims in 2016. Little information exists regarding services for CSE children who are not involved in the child welfare system.

The treatment model and services for CSE children require a therapeutic environment tailored to the child's needs.²¹ Florida's CSE residential programs share six main components: individual therapy, group therapy, substance abuse treatment, enrichment activities, faith-based opportunities, and education services.

Most providers stated that CSE children receive two one-hour sessions of individual therapy per week, with a minimum of one session per week. The majority said that they employ trauma-informed cognitive behavioral therapy for individual therapy, while a few stated that they tailor the type of therapy to the individual needs of the child. All but one provider have group therapy for residents at least once per week. Three providers include daily group sessions as a program component. All programs provide access to substance abuse therapy with frequency varying from one to three times per week depending on the child's needs.

CSE programs also include enrichment therapies and activities such as equine, music, poetry, art, and physical education for CSE child victims. Additionally, providers make faith-based opportunities, such as Sunday service and Wednesday youth group, available on a voluntary basis.

All providers must ensure that CSE child victims receive educational services. Approaches to education vary by provider and include on-site

²⁰ Sections 39.401(1-5) and 39.402 (1)(a-c), *F.S.*

²¹ These requirements include using a strength-based and trauma-informed treatment model, and providing specialized services such as victim-witness counseling, behavioral health care,

treatment and intervention for sexual assault, mentoring by survivors of sexual exploitation (if available and appropriate), access to substance abuse treatment, and transition planning services. These services may be provided directly, arranged for, or coordinated by the provider.

schools, private schools, and online educational programs. Some providers use different approaches depending on the needs of the child. One provider reported working with a public school guidance counselor to determine the best approach for each child.

Ensuring children receive an appropriate education poses multiple challenges for CSE providers. Many CSE child victims function below grade level, and providers report the children appear to lack motivation or refuse to participate in educational programs. In addition, providers report that for children who are placed outside of their home county, obtaining school records may take time and delay the child's participation in educational services.

Our case file review provided detail on DCF services available to CSE children, who remain in-home but receive needed additional family supports. Our file review of a sample of CSE children's cases identified the specific services and service referrals they received and provided a sense of their participation in services. Children in our case file review sample received case management services from the lead agency, and several children also received Medicaid Targeted Case Management from a mental health provider. Files showed that children were referred to individual and group counseling for mental health and/or substance abuse issues and to sexual abuse treatment services available from providers in the community. Children on psychotropic medications also received medication management. Further, most families in the case files were referred for family therapy to improve parent-child relationships. In addition to family therapy, parents received referrals for mental health and substance abuse services, parenting support and skills classes, and employment readiness or employment services. Some families also received crisis counseling services and behavioral analyst services.

While files showed that CSE children are referred to or attend therapy, this may not mean children actually participate regularly. Our file

review suggests that some children may refuse therapy. Further, children's participation may be intermittent because caregivers may live in rural areas and lack transportation, others lack health coverage, and some did not seem to fully comprehend the importance of services for themselves or their child.

Services received by more than half of CSE children are largely unknown. DCF does not maintain information on services to CSE children who do not become part of the child welfare system, 141 children in calendar year 2015.²²

The Department of Legal Affairs, Office of the Attorney General makes funding available for CSE children and other victims, including CSE children not adjudicated dependent. However, the department does not currently track CSE children separately from other victims. The Division of Victim Services has two programs available to children in the community who have been sexually exploited. First, the Bureau of Advocacy and Grants Management provides federal Victims of Crime Act grants to local agencies that serve victims of crime including human trafficking. In partnership with the Florida Department of Health and through the department's Sexual Abuse Treatment Program, the Office of the Attorney General provides funds for specialized treatment to any child living in the community who has a verified case of sexual abuse. Victims can receive a combination of individual, group, and family counseling. This program is administered locally by providers including Children's Home Society, child protection teams, and child advocacy centers. The Bureau of Advocacy and Grants Management currently does not track the number of CSE children who receive funded services. However, it anticipates it will be able to after implementing a new data system, which they anticipate will be in place after July 2016.

Second, the Division of Victim Services, Bureau of Victim Compensation provides assistance to victims of human trafficking. Through this

²² If a child is not dependent or receiving ongoing services from a lead agency, DCF does not have the legal authority to track the

child's progress in a referred treatment, unless the department receives a new report alleging maltreatment.

program, the Department of Legal Affairs may award compensation for counseling and other mental health services to treat psychological injury or trauma. Victims of human trafficking may also be awarded relocation assistance.²³ Up to \$5,000 can be paid for mental health treatment and \$1,500 for relocation assistance.²⁴

In State Fiscal Year 2014-15, the department received relocation assistance applications from 25 victims of human trafficking. This figure includes adult victims of sexual exploitation who are also eligible for this funding. The program does not separately identify relocation assistance recipients by age; it is unclear whether any of the 25 applicants were child victims of sexual exploitation.

Social Outcomes for CSE Children Identified in 2013-14

Many CSE children from 2013-14 are not making progress on short-term social outcomes

We examined the experiences of a cohort of CSE children identified in our 2015 report, which is referred to as Population 1 in the following discussion. Population 1 includes 170 children with verified CSE findings during the period from July 2013 through December 2014.²⁵ We looked at these CSE children's experiences in

three outcome areas: child welfare, criminal justice, and education. Within these areas, we examined specific indicators, such as re-victimization, arrests, school attendance, employment, and family reunification or continued DCF supervision.

A number of children aged out of care during 2015, so only a short timeframe was available to study outcomes for children from our previous study. Primarily, we measured the incidence of social indicators within several date ranges, depending on available data. Most commonly, we assessed social indicators from the date the CSE investigation was received until a child turned 18.²⁶ This allowed us to measure child outcomes for Population 1 over the child's time in any program, which varied from 1 month to 32 months. This allowed us to capture some indicators for all 170 children, but some children's outcome information covered just a short period.

Half of the children from Population 1 were the subjects of later DCF investigations of maltreatment. To examine the ongoing safety of Population 1, we considered subsequent involvement the child had with the child welfare system.

Our analysis found that 87 (51%) of the 170 children from Population 1 had subsequent investigations during our study timeframe.²⁷ Of the children with subsequent investigations, 36 had verified findings of any kind, and 29 children had verified findings of commercial sexual exploitation.^{28,29}

²³ Victims as described under s. 787.06(3)(b), (d), (f), or (g), *F.S.*

²⁴ Rule 2A-2.002, *F.A.C.*

²⁵ We are referring to the 170 children identified in [OPPAGA Report No. 15-06](#), for whom an investigation of CSE allegations was received by DCF between July 2013 and December 2014, and which ultimately resulted in verified findings of CSE.

²⁶ In order to provide the most comprehensive information on social outcomes, we also capture and report different start and endpoints, as appropriate. Depending on the data source, the data span ranges from the date the CSE investigation was received to December 31, 2015; for other social outcomes, we had an end date of March 12, 2016. Second, for some social outcomes, the time period covers the date a child victim of CSE was first placed in out-of-home care to when that child turned 18. Finally, when possible, we measured outcomes for children over a fixed, equal outcome window (e.g., outcomes through the

first year after children's CSE investigations for children for whom we had at least one year of information).

²⁷ For example, in DCF's data, children from Population 1 could be tracked from 24 days up to 975 days—an average of 537 days (or 17.4 months) depending on when the initial CSE investigation occurred and how old the child was at the time.

²⁸ As reported on page 5, we found that 22 of 170 children in Population 1 had verified findings of CSE in CY 2015. However, examining a longer time frame shows 29 of the 170 children had subsequent verified findings of CSE from July 1, 2013 through March 12, 2016.

²⁹ Similarly, of the 124 children we could track for a full year from the date the initial CSE investigation was received, half had at least one subsequent investigation within one year.

Many CSE children from Population 1 were involved with criminal justice agencies during our study timeframe. We also reviewed CSE children's encounters with the criminal justice system. To do so, we looked at children's arrests, their most serious charges after their CSE investigation was received, and whether or not they received services from DJJ.

According to our analysis of Florida Department of Law Enforcement (FDLE) and DJJ data, 107 (63%) of the 170 children in Population 1 were arrested in Florida at least once following their CSE investigation received date. Of these, we identified 94 children with DJJ records. Among the children with DJJ records, 69% of children from Population 1 were arrested more than once after the first verified CSE allegation was received for investigation.³⁰ Of the most serious charges associated with children's arrests, battery (including aggravated assault) was the most common, followed by larceny and probation violations. An additional 13 children were found only in FDLE's arrest data. At least three children in FDLE's records were arrested for prostitution-related offenses.

Over half (90) of the 170 children were involved with at least one form of DJJ services (detention, diversion, probation, and/or residential commitment) for at least one day after their CSE investigation received date.³¹ Most of these 90 children were admitted to DJJ detention, which typically happens following an arrest. Some were subsequently adjudicated to DJJ programs as well. (See Exhibit 4.)³²

Exhibit 4 Many CSE Children in Population 1 Had DJJ Involvement

DJJ Services	Number of Children
Detention Services	78
Diversion Services	18
Probation and Community Intervention	55
Residential Commitment Programs	20

Note: N=90 children. Placement counts may duplicate children, as a child may spend time in several DJJ services over time.

Source: OPPAGA analysis of Department of Juvenile Justice data.

Many CSE children from Population 1 struggled with attending and completing their K-12 education. We also examined education outcomes for CSE children using Department of Education (DOE) information on current school enrollment, attendance, and grade level.

First, we found K-12 school enrollment information for 120 of the 170 children in Population 1 during the 2014-15 academic year.³³ The children we could identify as enrolled likely attended a couple of schools within that year, resulting in multiple enrollments for some children. Attending multiple schools could be due to placement changes, especially if children were moved to out-of-home placements. Of the total 160 K-12 school enrollments we identified for 120 children in Population 1 during 2014-15, 100, or 62%, were for alternative schools. (See Exhibit 5.) Most of these alternative school enrollments were within DJJ's secure detention and residential commitment facilities.

³⁰ Some children's records are found in both FDLE and DJJ data. How charges are categorized differs between the agencies and the respective databases. As a result, we provide counts of repeat arrests and type of arrest using only DJJ records.

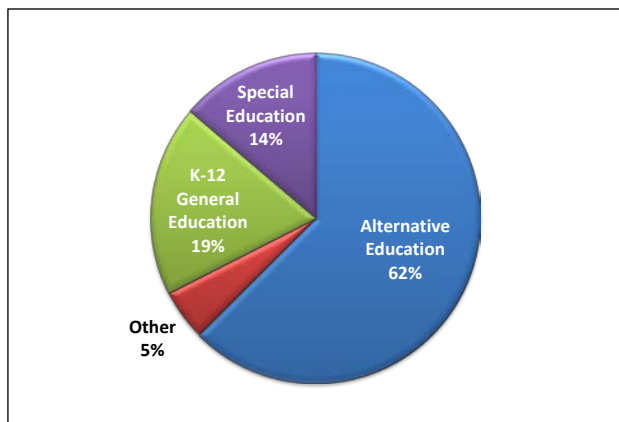
³¹ We did not count children who had been in intake or prevention services.

³² Similarly, 66 children who could be tracked for at least one year received DJJ services at least once during that year.

³³ In academic year 2014-15, 46 children had no K-12 or continuing education enrollment records. Two children were too young to enroll in school. We cannot determine whether or not the rest

of the children were enrolled in school. Children may be enrolled in school but not appear in our data for several reasons. First, the identifying information for the children in Population 1 may be inconsistent between DCF and DOE's data. Second, enrollment records are not available for children who attended school out of state or attended private or home school. For example, the two safe houses that reported using private education could account for some missing enrollees. As a result, the counts of enrollment, attendance, and highest grade completed may be low.

Exhibit 5 School Enrollments for CSE Children in Population 1 Are Mostly in Alternative Education



Note: N=160 documented enrollments.

Source: OPPAGA analysis of Florida Department of Education data.

Of the 120 children we found that were enrolled in K-12 education, 53% attended for less than half the academic year. Because only 9 of the 120 enrolled CSE children in Population 1 were age 18 or older at the start of the school year, we cannot assume that limited attendance is solely due to children being too old to be enrolled in 2014-15. Our file review suggests that children typically attended school when they were in out-of-home placements, but did not attend regularly or were truant if they were on the run or receiving DCF services in a family setting.

Our case file review supported this, generally indicating that few CSE children attended

school regularly unless they were in an out-of-home placement.

Further, for the 2014-15 school year, 87 (73%) of the 120 children in Population 1 who were enrolled in school were in a grade level that was lower than might be expected based on age. Our review of CSE children's case files found that Population 1 children have histories of poor academic performance, which may be due in part to limited school attendance. In addition, a few children had diagnosed learning or emotional disabilities.

Few of the older CSE children appear to have completed high school or received post-secondary education.³⁴ Since the 2012-13 academic year, three children from Population 1 received a diploma, and four children had continuing education enrollments in Florida. These continuing education enrollments were likely dual enrollment or adult education since these children had not yet earned a diploma from a Florida public school. In addition, 13 children took some adult education, primarily in pursuit of a GED.

A few age-eligible CSE children worked at UI covered employment. Employment information for CSE children is drawn from employer reports for those who worked in occupations covered by unemployment insurance. From the third quarter of 2013 to the third quarter of 2015, 29 CSE children from Population 1 worked in an unemployment insurance-covered job in Florida. Most employed children were 17 or 18 years old, and most held food service jobs.

Most CSE children who had been placed out-of-home had not been discharged from DCF's supervision by the end of 2015. We also reviewed whether Population 1 children remained in DCF's care over the course of the study period or had been discharged. We found that 32 of the 50 children who had been in out-of-home care remained in out-of-home care or

³⁴ Continuing education data used in this analysis includes information about enrollments in Florida's public schools, public colleges and universities, and non-for-profit independent

colleges and universities. We had no way of tracking CSE child participation in for-profit colleges or institutes, such as culinary or cosmetology schools.

extended foster care.³⁵ The remaining 18 of 50 children were discharged from out-of-home care.³⁶

A review of children's stay in DCF's care must also consider children's age, as this affects their eligibility and length of potential stay. A few children in Population 1 aged out. The 12 children who were 17 years old when they were first in out-of-home care after their CSE investigation was received had limited time (2 to 11 months) to be discharged before turning 18. Eleven of these 12 children aged out, and 8 of these 11 children entered extended foster care.³⁷ Young adults in the case file review who were entering extended foster care appeared to have difficulty complying with the program requirements (e.g., enrollment in a post-secondary educational or vocational program and stable housing). For several children, participation in extended foster care ended when they opted out of the program, were expelled from GED classes, or were terminated for lack of compliance.

The remaining 38 of the 50 children had a longer time to achieve permanency since they were younger when they entered care (an average of about 22 months before the child turned 18 or the end of our study period).³⁸ However, during this time, only 10 had been discharged to the care of a permanent family. Six of the children aged out of care while the remaining 22 were still in out-of-home care at the end of the study timeframe.

Frequent treatment interruptions make it difficult to attribute treatment effects to any single type of placement

Because children in Population 1 changed placements many times, it would not be appropriate to attribute any progress or lack thereof to a single provider or service model. The 50 CSE children from Population 1 who

spent time in out-of-home care after their CSE investigation was received averaged 5.4 DCF placements per year. However, when placement disruptions (e.g., running away) are counted, these children changed placements an average of 8.3 times annually.

Placement changes can indicate positive change in a child's life. For example, a child might be moving to be near her own child or progress in a child's mental health and substance use might warrant a change to a less restrictive environment. However, data indicates that running away from placements is a common reason for a child's placement to be changed in a given year. Among the 50 children from Population 1 who were placed in out-of-home care, 36 ran away from care at least once. (See Appendix E for a visual presentation of CSE children's running patterns.) Population 1 children ran from all types of placements.

We analyzed children's running patterns and noted two patterns. First, when we looked at running only in terms of types of placements from which children ran, the runaway rate is highest for safe houses and regular group care. Sixty percent of safe house placements and 50% of group care placements include a runaway episode.³⁹ This is consistent with studies on the general child welfare population, which indicate that adolescents in group care run frequently.

However, when we looked at the rates of running over a specific length of time that children spent in the placement, a different pattern emerged: over time, CSE children ran more often from foster home placements. Specifically, when looking at runaway incidents per 100 days in a type of placement, therapeutic and traditional foster care have the highest runaway rates (1.8 runs per child per 100 days), followed by emergency shelters, safe houses, then group care. This is a likely outcome of

³⁵ This considers whether the child had left out-of-home care before March 12, 2016.

³⁶ Discharged CSE children from Population 1 spent an average of 360 days in out-of-home care from the time that their CSE investigation was received.

³⁷ According to s. 39.6251, *F.S.*, children may remain in extended foster care until they are 21 years of age.

³⁸ March 12, 2016.

³⁹ The number of runs includes temporary placements.

many CSE children spending almost a third (30%) of their out-of-home placement time in family settings.⁴⁰

Findings from our small sample are consistent with interviews with case managers and providers, which suggests that running is a typical behavior pattern for CSE children. Moreover, lead agency staff and case managers we interviewed felt that CSE children seemed to run more frequently than other children they serve. They also noted that running shortens a CSE child's exposure to treatment and disrupts continuity of care.

State Agency Human Trafficking Update —

Agencies are working to better identify CSE victims through community awareness, training, and the screening tool

Several state agencies report engaging in community awareness and training efforts across the state. The difficulty in identifying CSE children heightens the need for training for child welfare and juvenile justice staff, law enforcement, educators, and school personnel, as well as greater community awareness of commercial sexual exploitation. DCF staff reported conducting CSE trainings in the latter half of 2015 and early 2016 in its northern, central, and southern regions for child protective investigators (CPIs), lead agencies, service providers, law enforcement, and other stakeholders. Additionally, the department partnered with a non-profit organization to produce a televised public service announcement that has aired in Tampa, Pensacola, and Jacksonville.

Other state agencies are conducting outreach and training to help agency staff and local communities better identify CSE children.

- DJJ staff reported that the department has conducted CSE training for DJJ and provider staff and judges and is in the process of training its prevention providers. Additionally, the department has developed administrative guidance for providers and other stakeholders to administer the screening tool.
- FDLE and the Office of the Attorney General collaborated to develop an introductory training on human trafficking for law enforcement officers that can be counted toward officer recertification training requirements.
- According to Florida Department of Education staff, the department provides materials on human trafficking to the school districts and provides training to districts that request it. DOE also provides human trafficking training to bus drivers, student resource officers, and nurses multiple times each school year.
- As of January 1, 2016, Ch. 2015-172, *Laws of Florida*, requires the Department of Transportation, the Department of Health, and certain employers to display human trafficking awareness signs at specified locations, including rest areas, emergency rooms, and airports.

DCF and DJJ developed a screening tool to systematically identify CSE victims; concerns about the tool exist among CPIs and others. As directed by Florida statutes, DCF and DJJ convened a workgroup to develop the Human Trafficking Screening Tool to screen both potential CSE and labor trafficking victims.⁴¹ Statutes state that the tool must be used by CPIs, lead agencies, and DJJ juvenile assessment centers to screen potential CSE victims. DJJ implemented the screening tool in its juvenile assessment centers and with juvenile probation officers in April 2015. In the first year, DJJ staff completed a total of 3,500 screenings on 2,500 youth.⁴² The screenings resulted in 1,289 calls to

⁴⁰ Please see Exhibit 3.

⁴¹ Section 409.1754 (1)(a), *F.S.*

⁴² This is a count of DJJ-administered human trafficking screening tools from March 2015 through March 2016.

the Florida Abuse Hotline, and staff accepted 52% of these calls for intake.⁴³

DCF staff reported that the screening tool was implemented statewide among CPIs and lead agency staff in January 2016. In May 2016, DCF staff reported that a review was under way of completed screening tools. DCF plans to compare the number of children identified in FSN data who had characteristics that should have triggered a CSE screening to the actual number of completed screenings.

While the agencies have separate instructions on when to administer the tool, both sets of instructions require staff to administer the tool if a child has a history of running away or if the child's parents have barred the child's return to the family home four or more times or if the child has a history of sexual abuse.

As of March 2016, all of the lead agency staff we interviewed reported that their lead agency had either implemented the screening tool or was planning to implement it in the coming months. Some lead agency staff we interviewed expressed concerns that the indicators used to determine when a child is screened for CSE are very broad and result in a high number of screenings, which staff described as being time consuming.

CPIs we interviewed expressed dissatisfaction with the tool. They expressed concern with the length of the tool, the order of the questions, redundancy of the information requested, and the way many of the questions are worded. Some CPIs stated that they do not use the tool because they feel it does not allow for rapport building or that the length of the document intimidates the victims. Additionally, CPIs said responses to the tool's questions may be more appropriate when assessing a child for services, but are not always relevant to the beginning of an investigation. Further, CPIs we spoke to felt that the tool is more appropriate for use at a

juvenile assessment center, as it is difficult to administer in the field. Juvenile assessment center staff we interviewed, who routinely conduct formal assessments of children, reported that they are using the tool. They noted that the tool is lengthy, but did not report any issues with administering it.

DCF continues to update its policies and procedures regarding victims of commercial sexual exploitation. In addition to the development and implementation of the screening tool, DCF has incorporated hotline intake and child protective investigation instructions for cases involving CSE victims into its standard operating procedures.⁴⁴

In July 2015, the department updated its child maltreatment index to designate a single maltreatment code for CSE victims. For the first half of CY 2015, DCF hotline staff were still using multiple maltreatment codes. In order to properly identify all CSE children for 2015, DCF staff manually reviewed case files for the children who may have been incorrectly categorized under the former maltreatment codes from January through June of 2015.⁴⁵

Department staff said that they monitor the use of the outdated codes and provide feedback to hotline supervisors if reports appear to be inappropriately coded. The use of the outdated maltreatment codes resulted in four cases being excluded from our analysis. Hotline staff received training on the updated maltreatment code procedures in June and July of 2015.

DCF now has a placement tool for lead agencies and adopted a rule for a CSE provider certification process

DCF developed a new placement tool. To assist lead agencies in determining the appropriate level of services and placement for CSE children, the department developed the Level of Human Trafficking Placement Tool, which

⁴³ Of the total reports by DJJ staff to the DCF hotline, reports regarding 576 children were accepted for intake. However, this number may include both CSE children as well as labor trafficking victims who are identified through the screening tool.

⁴⁴ Department of Children and Families Operating Procedure No. 170-2 and 170-5.

⁴⁵ This issue with the maltreatment codes was discussed in OPPAGA [Report No. 15-06](#).

was implemented statewide in January 2016. The tool is designed to be utilized by the multidisciplinary team to assess the array of interventions and placement options for the child on an individualized basis. The tool has five domains, such as the child's risk of running and motivation to engage in treatment. The service and placement options range from outpatient counseling to secure residential treatment programs.

Florida statutes direct DCF to certify specialized residential programs and specify services that providers must offer. As noted above, Florida statutes address specialized residential options for CSE victims including safe homes, safe foster homes, residential treatment centers, and hospitals that provide residential mental health treatment.⁴⁶ Statutes further require DCF to develop certification requirements for safe houses and safe foster homes.⁴⁷ DCF established the certification process for safe houses and safe foster homes in rule as of January 2016.⁴⁸ The department plans to certify new providers as part of the licensure process. Department staff reported that as of June 2016, all current safe homes and safe foster care programs had initiated the certification process but none had completed the process to become certified.

DCF continues its work to identify effective treatments and interventions for CSE victims; data system has limited service information

Best practices are not available for DCF and lead agencies to determine the appropriateness of services provided to CSE victims. Neither governmental nor other experts have identified best practices and a standardized model of care for CSE victims. While many providers reported providing similar types and frequencies of services this year, we are unable to determine whether the

service types or frequencies are appropriate or effective.

Responding to the lack of recognized best practices, DCF has established five clinical workgroups to explore how to best meet the needs of the CSE population. Members of the workgroups include DCF staff, CSE-specific residential provider staff, lead agency staff, and clinicians. The Treatment and Interventions Workgroup is charged with identifying what types of treatment are effective, interventions that Florida should be exploring or researching, and existing barriers to treatment.

Additional research on effective interventions would allow DCF to offer informed guidance to both lead agencies and other contracted providers. For example, DCF could disseminate best practice guidance on program duration, which currently varies among safe house providers. While some safe houses identified themselves as long-term placements willing to house victims for years, others told us that after four to six months victims need to move to a less restrictive, more normalized setting.⁴⁹ Safe houses, while home-like, are recovery programs with multiple restrictions and facility-type attributes, including prohibitions on cell phones and social media, statutorily required 24-hour awake staff and security such as door exit alarms.⁵⁰ With more information on CSE children's recovery processes, lead agencies could more confidently place CSE children in less restrictive, less expensive settings as appropriate. Currently, the policies and procedures for moving CSE children remain the same as for other children in the child welfare system, without information about whether this is appropriate.

Limited aggregate information is available on services provided to CSE children. More information is needed to assess the services provided to CSE child victims. Florida's child welfare system is decentralized and services are

⁴⁶ Sections 409.1678(1) and 409.1678(3), *F.S.*

⁴⁷ Section 409.1678(2), *F.S.*

⁴⁸ Chapter 65C-43, *F.A.C.*

⁴⁹ Section 39.6012(1)(a), *F.S.*; Rule 65C-30.009, *F.A.C.*

⁵⁰ Section 409.1678(2), *F.S.*

provided by private vendors who have contracted with lead agencies. While information documenting the frequency, duration and types of services received by CSE child victims is likely maintained by the provider and shared via the case manager with others as needed, it is not readily available for review or analysis.

DCF's Florida Safe Families Network (FSFN) serves as the case management system for the state's child welfare programs; it is not used to collect or maintain quantitative data on services children receive. In the absence of systematic data on services provided to CSE children, we conducted interviews with CSE-specific residential providers as well as a file review of a sample of CSE cases.

Information gathered from providers and file reviews contain important limitations. First, information gleaned from residential providers is self-reported and limited to children in CSE residential placements, which excludes those in non-CSE placements or those receiving in-home services. Second, we found through the file review of CSE cases that files contained inconsistent or limited information for services that in-home children were receiving. For children whose care was provided out of home, more detail was available on the frequency and type of services received.

DCF is working to identify appropriate measures of effective interventions for CSE children

Providers continue to use a variety of methods and criteria to monitor CSE children's progress. Providers reported using structured instruments to assess progress toward individualized treatment plan goals. For example, two providers reported using an

established tool to evaluate reduction in post-traumatic symptoms including anxiety, sexual behavioral issues, and withdrawal.⁵¹ However, not all providers utilize assessment instruments. Some providers report that they monitor behavioral changes, such as compliance with safe house rules, less frequent use of profanity, and positive socialization with peers. Lastly, providers cited progress in a child's treatment/care plan based on engagement, positive participation in therapy, and educational improvement.

Because providers do not use consistent methods to evaluate progress, DCF program staff reports receiving mostly anecdotal information about child progress.

DCF is working to identify appropriate short-term outcome measures of CSE children's progress. Given that there is very little information nationally on outcomes for the CSE child population, DCF staff report that they have also set up a metrics and outcomes workgroup to determine what indicators are most appropriate to measure progress with CSE children.

The DCF workgroup's efforts focus on information from an ongoing, independent evaluation of a single CSE provider that provides specialized therapeutic foster care or community response team services, depending on the needs of the child.⁵²

While DCF reports that the evaluation provides unique information about CSE children, it is important to note that results of the evaluation may not be generalizable because the provider's service model is unlike any other program for CSE children in Florida. This program provides wrap around services and assigns a therapist to each CSE child who continues to provide services no matter where that child is placed

⁵¹ Trauma Symptom Checklist for Children™

⁵² Children in the program receive services including individual therapy, family therapy, life coaching, group therapy, Medicaid Targeted Case Management, and behavioral analyst services, as indicated. Services are available to community children, dependent children in out-of-home care settings, children who meet the Medicaid criteria for specialized therapeutic foster

care, or in the provider's Statewide Inpatient Psychiatric Program. Children are evaluated upon entrance and every three months thereafter until exiting program. Staff measure children's strengths, such as leadership skills, life skills, optimism, and interpersonal skills through therapist assessment, caregiver assessment, and youth self-report.

and regardless of how long the child is in care. The vast majority of CSE children, many of whom move across a range of placements, will not have this continuity of care.

Conclusions and Recommendations

With improvements to the Florida Abuse Hotline operations, the implementation of a screening tool, and the development of certification criteria that could standardize safe house services, the state has heightened its efforts to identify and address the needs of child victims of commercial sexual exploitation.

We recommend that DCF gather systematic feedback from users about the screening instrument. In 2015, we recommended that the state agencies take steps to ensure that CPIs, case managers, and juvenile assessment centers properly and consistently use the screening tool. DJJ human trafficking staff visited juvenile assessment centers and received feedback about the instrument. Further, because the screening tool is automated at DJJ, human trafficking staff review juvenile assessment center data entry related to the screening tool and provide feedback to improve the information gathered in the tool.

Given the recent statewide release of the screening tool to lead agencies, DCF may also wish to consider gathering feedback from lead agencies or CPIs regarding the screening tool's implementation. Feedback from additional users could help the agencies determine what modifications, if any, to make to the instrument.

We further recommend that DJJ and DCF validate the screening tool when sufficient data and support are available to do so. Chapter 2014-161, *Laws of Florida*, requires the human trafficking screening tool to be validated, if possible. DJJ will lead validation activities for the tool, and has begun collecting information on the number of children identified as potential CSE child victims that are accepted for intake by the DCF hotline.

However, to date, DJJ has had to rely on its screening information to validate the tool because the DCF tool is not automated. We recommend DCF consider automation of the tool and prioritizing the validation of the screening tool as resources allow. The department has submitted a request to automate the tool; however, the system changes required for the department's new child welfare practice model are likely to be addressed before the tool.

Validating the screening tool is important to verifying the accuracy with which the state is identifying CSE children. This tool has been thoroughly researched and has some degree of face validity, which is progress, but without data to ensure that it is measuring what it is intended to measure, it is simply an additional task for children and agency staff to complete.

Validating the screening tool is also important because it is the first in a potential sequence of tools for lead agencies and case managers to use for serving CSE children. Notably, appropriate use of the placement tool and any forthcoming assessment tool is contingent on accurate screening. The screening tool will also affect whether these other tools are utilized. Validating the tool might also highlight particularly predictive questions, and allow the agencies to shorten the tool and lower staff workload.

Finally, a validated screening tool could help both agencies identify key risk factors for CSE child victims. Such information could be helpful in identifying at-risk children and developing appropriate prevention or diversion services.

As DCF works to identify relevant treatment outcomes for CSE children, we recommend that it consider data representing the diverse needs and placements of the CSE population. Many CSE children struggle with key social issues such as safety, permanency, and education. Because children who are commercial sexual exploitation victims frequently have significant psychological and behavioral issues and because treatment is

expensive, determining appropriate outcomes and approaches to care (including treatment model and duration of treatment) is critical.

DCF has established a research workgroup to review outcomes from an independent evaluation of a single program for CSE children. However, this one program has a different treatment model than any other specialized provider in Florida. Developing statewide policy direction and appropriate metrics will benefit from the current broad array of service delivery models rather than a single program.

We recommend that DCF consider the data from additional Florida interventions and providers. For example, lead agencies may place CSE children at residential treatment centers for more serious substance abuse and mental health needs. These centers collect a range of systematic information on children's

progress and could potentially be a rich source of additional information for DCF to consider as it develops outcomes for CSE children.

Agency Response ———

In accordance with the provisions of s. 11.51(2), *Florida Statutes*, a draft of our report was submitted to the Secretaries of the Department of Children and Families and the Department of Juvenile Justice. The departments' written responses have been reproduced in Appendix F.

OPPAGA supports the Florida Legislature by providing data, evaluative research, and objective analyses that assist legislative budget and policy deliberations. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021), by FAX (850/487-9213, in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). Cover photo by Mark Foley.

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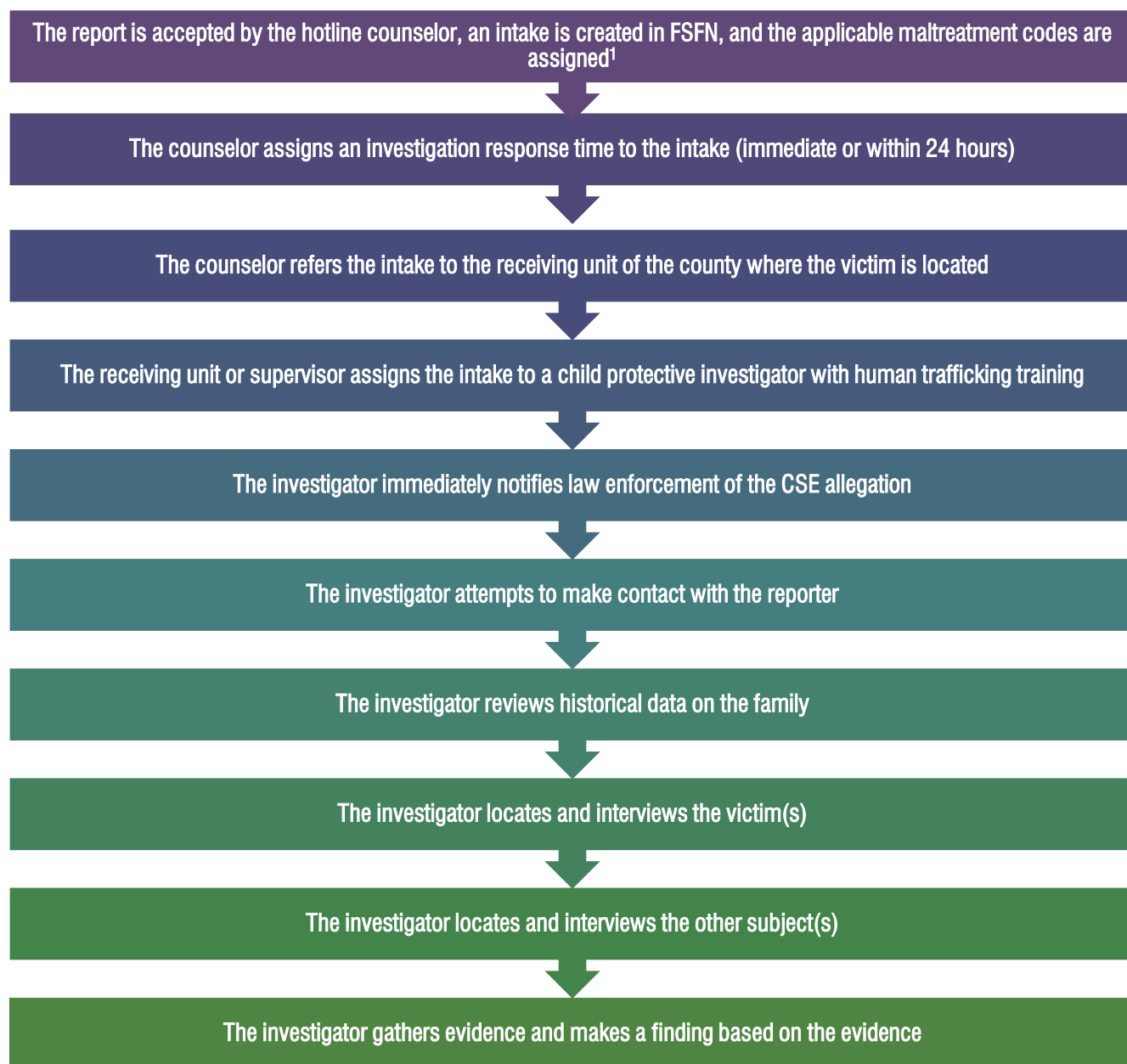
Project supervised by Mary Alice Nye (850/717-0567)

Project conducted by Emily Leventhal, Cate Cantral, Drucilla Carpenter, Michelle Ciabotti, Anne Cooper, and Justin Graham
R. Philip Twogood, Coordinator

Appendix A

DCF Intake and Investigation Process

All reports of commercial sexual exploitation of children go through DCF's Florida Abuse Hotline. Hotline staff determines whether the allegation meets statutory criteria for sexual exploitation; if so, the call is referred to a child protective investigator. The primary steps in the intake and investigation process are outlined below.



¹ FSFN is the Department of Children and Families' Florida Safe Families Network data system.

Source: OPPAGA analysis of Department of Children and Families Operating Procedures 170-2 and 170-5.

Appendix B

County-Level Prevalence Data

OPPAGA's analysis identified 264 verified child victims of commercial sexual exploitation (CSE) in CY 2015. Victims were identified in 39 counties. The majority of verified victims were in Miami-Dade, Hillsborough, Broward, and Orange counties. See Exhibits B-1 and B-2.

Exhibit B-1

Verified Victims of Commercial Sexual Exploitation

Community-Based Care Lead Agency	County	Verified CSE Victims	Percentage of Verified CSE Victims
Big Bend Community-Based Care, Inc.	Bay	1	0.4%
	Leon	1	0.4%
	Gadsden	1	0.4%
	Washington	1	0.4%
Brevard Family Partnership	Brevard	7	2.7%
Community-Based Care of Central Florida	Orange	24	9.1%
	Osceola	3	1.1%
	Seminole	6	2.3%
ChildNet, Inc.	Broward	26	9.8%
	Palm Beach	7	2.7%
Children's Network of Southwest Florida	Charlotte	1	0.4%
	Collier	1	0.4%
	Lee	7	2.7%
Community Partnership for Children, Inc.	Flagler	2	0.8%
	Volusia	5	1.9%
Devereux Families Inc.	Martin	1	0.4%
	Okeechobee	1	0.4%
	St. Lucie	2	0.8%
Eckerd Community Alternatives	Hillsborough	33	12.5%
	Pasco	2	0.8%
	Pinellas	6	2.3%
Families First Network	Escambia	9	3.4%
	Okaloosa	2	0.8%
	Santa Rosa	3	1.1%
	Walton	4	1.5%
Family Support Services of North Florida, Inc.	Duval	15	5.7%
Heartland For Children	Highlands	1	0.4%
	Polk	20	7.6%
Kids Central, Inc.	Citrus	1	0.4%
	Lake	1	0.4%
	Marion	3	1.1%
Kids First of Florida, Inc.	Clay	3	1.1%
Our Kids of Miami-Dade/Monroe, Inc. Partnership for Strong Families	Miami-Dade	45	17.0%
	Alachua	7	2.7%
	Bradford	1	0.4%
	Madison	3	1.1%
	Taylor	1	0.4%
Sarasota Family YMCA, Inc.	Manatee	5	1.9%
	Sarasota	2	0.8%
State total		264	100.0%

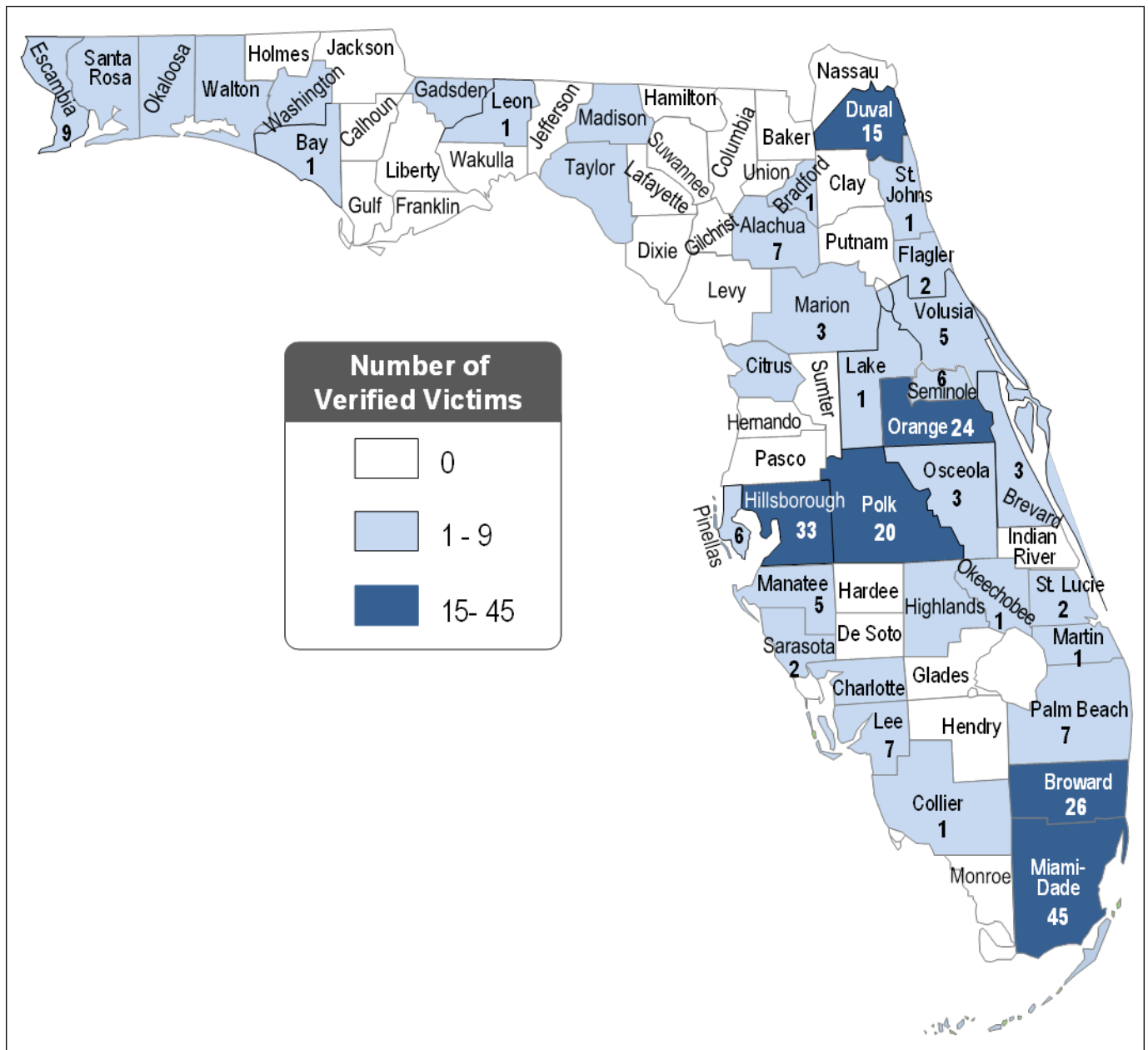
¹ Counties not listed did not have any verified victims during our timeframe (though they may have had investigations). Counties presented above were the counties of CSE children's initial intake.

² Column data may be in excess of 100% due to rounding.

Source: OPPAGA analysis of Department of Children and Families data.

Exhibit B-2

Number of Verified CSE Children by County



Source: OPPAGA analysis of Department of Children and Families data.

Appendix C

Profile of Florida CSE Children

Research on child victims of commercial sexual exploitation (CSE) is limited by a lack of information on child victims and in-depth review of their social context. Below is a profile of CSE children and potential risk factors for CSE that we obtained from analysis of automated data for calendar year 2015 for 264 verified CSE children (in blue) and case files of 24 CSE children receiving in-home or out-of-home services (in green) from July 2013 through December 2014 from DCF's Florida Safe Families Network (FSFN) system.

Exhibit C-1

Social Characteristics of CSE Children

264 Children with Verified Findings of CSE During Calendar Year 2015

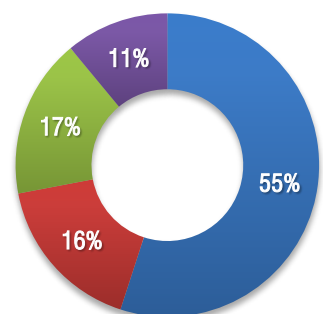
93% Female
7% Male

Age: 92% were between 14 and 17 years of age

Race: White 51%, Black 40%, Other 9%

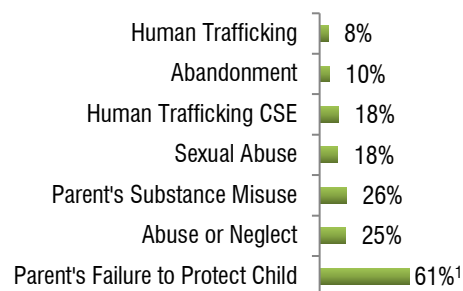
Family Context, Calendar Year 2015

More than Half of CSE Children Were Living with Parents at Their CSE Investigation



■ Parent Household ■ Residential Care
■ Non-Parent Care ■ Other

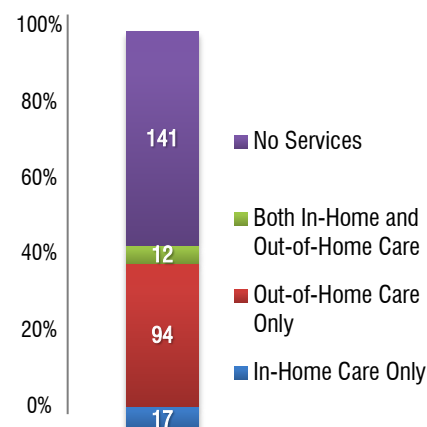
For CSE Children with Prior Maltreatments, 56% Had Multiple Prior Maltreatments



Parent's Failure to Protect Child includes Inadequate Supervision, Family Violence Threatens Child, Threatened Harm, Failure to protect, and Environmental Hazards maltreatments.

¹ This number was recorded incorrectly as 87% in a prior report release.

Almost 50% of Children with Verified CSE were Served by DCF



Challenges for Serving CSE Children, June 2013 through December 2014

Mental Health

Case files show incidence of:

- mental health hospitalization;
- PTSD;
- depression;
- anxiety;
- mood disorders; and
- bipolar disorder.

Substance Abuse

Most of the children in the case file review sample admitted to use of illegal substances, including:

- alcohol;
- cannabis;
- amphetamines; and
- narcotics.

Delinquency

Many children in the case file review had current or prior interactions with the criminal justice system, including:

- violating probation;
- assault; and
- drug possession.

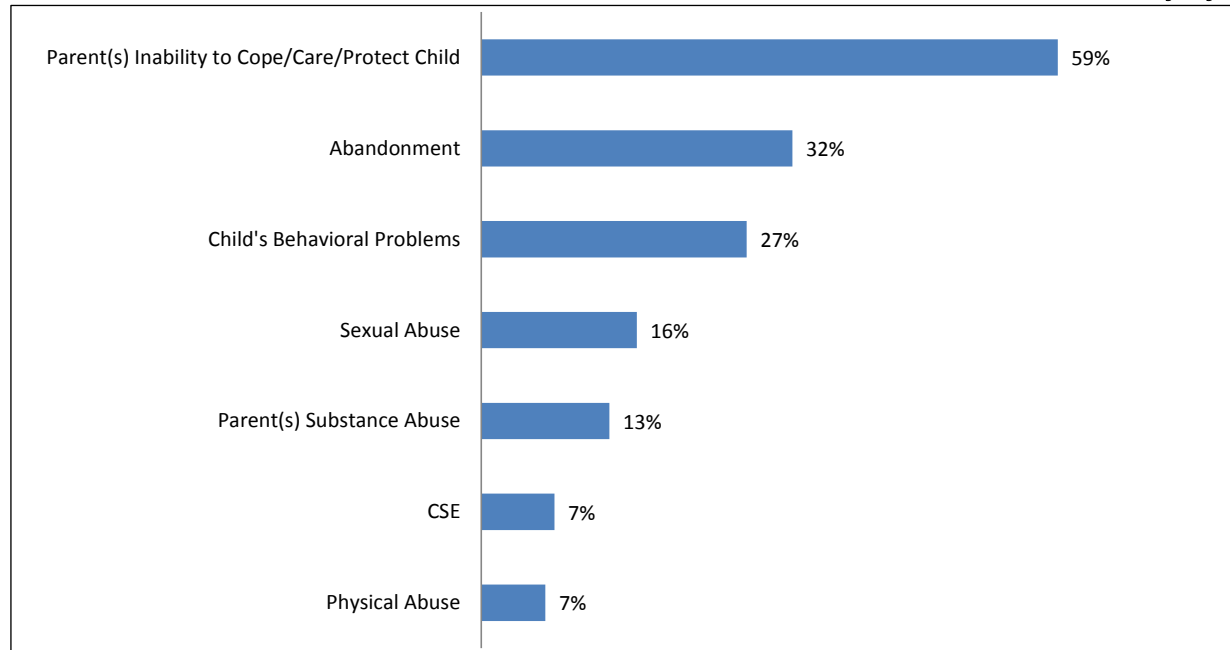
Most child CSE victims are exploited by adults, although some are soliciting sex for survival. Based on our case file review of 24 cases of verified CSE children, most children were involved with an adult exploiter, such as an older male acquaintance, parent, or grandparent. Other children engaged in sexual activity for personal material gain, with a few also acting as recruiters. Many CSE children did not see themselves as victims, denied their involvement in CSE, or saw nothing inappropriate about these behaviors. This seemed especially true in situations where the exploiter simulated a romantic or familial relationship.

A variety of factors put children at risk for commercial sexual exploitation. Prior history of abuse or neglect may be a risk factor for commercial sexual exploitation of children. Of the 264 children with verified CSE, 56% (146) had at least one prior verified maltreatment. Of the children with prior maltreatments, 18% had a prior maltreatment of CSE and 18% had a prior maltreatment of sexual abuse, a recognized risk factor for CSE, especially among females.

National studies have found that family stressors, such as parental substance misuse and family dysfunction, can also serve as risk factors for the CSE of children.⁵³ These factors appear to be supported by our analysis of FSN data—the majority of the 106 children were removed because of the parent’s or caregiver’s inability to care for or protect the child (59%), abandonment (32%), or inability to cope with the child’s behavior (27%).⁵⁴ (See Exhibit C-2.) In addition, 13% of children were removed due to their parent’s substance abuse.⁵⁵ Our file review also showed that family stressors, such as poverty, unemployment, parental incarceration, or family dysfunction, such as parental substance and/or mental illness, domestic violence, and involvement with the child welfare system were present in nearly every case.

Exhibit C-2

In Calendar Year 2015 Most Children Removed From Their Homes Were Removed Due to Family Dysfunction



Note: Children may have multiple removal reasons based on the findings of an investigation; no child was removed solely for CSE.

⁵³ *From Research to Practice: Identification and Assessment of Domestic Minor Sex Trafficking (DMST)*, Center on Violence Against Women and Children, Rutgers University School of Social Work, 2014.

⁵⁴ Inability to care for or protect the child includes incarceration, inadequate supervision, inadequate housing, and parent’s inability to cope.

⁵⁵ Children may have multiple removal reasons based on the findings of an investigation.

Source: OPPAGA analysis of Department of Children and Families data.

Children in out-of-home care, who have been removed from their homes because of child abuse or neglect, are at particularly high risk of being exploited. The U.S. Department of Health and Human Services cited a number of studies that found from 50% to over 90% of child victims of CSE had been involved with child welfare services.⁵⁶ This finding was corroborated by our analysis of FSFN data which found that, of our 264 verified CSE children, 87 received prior in-home services and 108 received prior out-of-home services.⁵⁷

The trauma associated with abuse and neglect may also negatively affect a child's mental health, creating feelings of powerlessness, or motivating youth to seek support outside their home environment.⁵⁸ Our review of case files showed that CSE children had an array of diagnosed mental, emotional, and intellectual disabilities. The majority of CSE children had a mental health diagnosis at the time of the CSE investigation. These diagnoses include one or more of the following: bipolar or other mood disorders, depression, ADHD/ADD, oppositional defiant disorder, conduct disorder, schizophrenia, PTSD, and anxiety. Many CSE children were on one or more medications to treat mental health issues. A few children in the file review sample had significant intellectual disabilities. In addition, the case file review found a number of children in the sample had previous inpatient or outpatient mental health treatment.

Delinquent behaviors also may be risk factors for CSE. Researchers have identified a number of delinquent behaviors as risk factors for CSE including substance use, gang involvement, and a prior history with the juvenile justice system.⁵⁹ Our case file review found that many children had current or prior involvement with the juvenile justice system unrelated to current CSE involvement, including arrests, detentions, probation, and commitment for crimes including assault, battery, retail theft, larceny, criminal mischief, resisting arrest, disorderly conduct, and drug possession. At the time of the CSE investigation, for those children adjudicated as delinquent, many were on probation and/or in a juvenile detention center, often the result of violating the terms of their probation. Most of the children in the case file review sample admitted to use of illegal substances including alcohol, marijuana, amphetamines, and narcotics.

⁵⁶ *Child Welfare and Human Trafficking*, Child Welfare Information Gateway, U.S. Department of Health and Human Services, Children's Bureau, 2015.

⁵⁷ Those children receiving in-home or out-of-home care may have received either or both.

⁵⁸ *From Research to Practice: Identification and Assessment of Domestic Minor Sex Trafficking (DMST)*, Center on Violence Against Women and Children, Rutgers University School of Social Work, 2014

⁵⁹ *Ibid.*

Appendix D

Array of Placement Options for CSE Children

Regardless of whether a child is verified as a CSE victim, when a child welfare professional determines that services are necessary to ensure any child's safety, permanency, and well-being, the least to most intrusive options must be considered.

- The child remains in their home with no judicial actions.
- The child remains in their home with judicial actions.
- The child is placed out of their home temporarily.⁶⁰

Lead agencies identify placements at two points: (1) when children enter care for the first time, and (2) when children already in care move to another placement. Regardless of the type of placement, lead agencies rely on available child information for the placement process. For children initially entering care, this is predominantly information gathered by the child welfare child protective investigator, the family functional assessment administered by the case manager, and a comprehensive behavioral health assessment, when it is available.⁶¹ For children already in care, typically more information is available, including additional evaluations, education records, and the child's needs and placement history. With this information, a child welfare professional must consider the least restrictive placement that can safely care for the child and identify a program that is able to accept the child.⁶²

While information on a child may change over time and with continued assessment, the placement matching process is generally the same whether this is a child's initial placement or any subsequent placement. For CSE children, multi-disciplinary teams consisting of members such as lead agency staff, law enforcement, child protection team representatives and a CSE child's case manager may be convened to decide on an appropriate setting for each CSE child.

To serve the varying needs of all children in out-of-home care, the department has arranged for an array of placement settings. See Exhibit D-1 for the continuum of care from least restrictive to most restrictive.

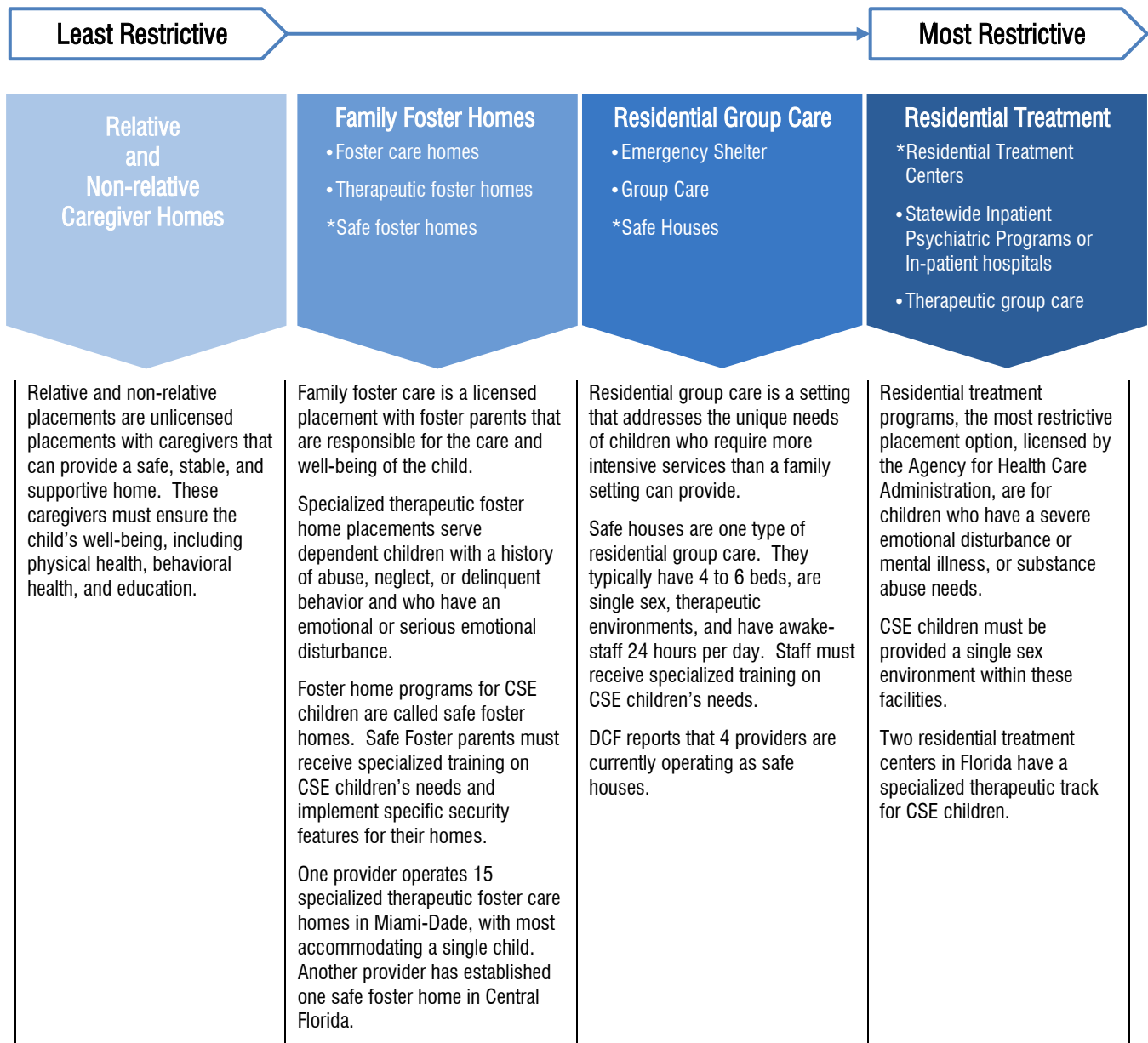
⁶⁰ Section 39.6012 (1)(a), *F.S.*; Rule 65C-30.009, *F.A.C.*

⁶¹ A comprehensive behavioral health assessment (CBHA) is a Medicaid-funded in-depth assessment of a child's emotional, social, behavioral, and developmental functioning within the family home, school, and community, as well as the clinical setting. A CBHA provides specific information about the child's mental health and related needs and identifies services to address these needs. The assessment results should be included in the child's case plan and any therapeutic treatment plan, and when available, a CBHA should be used to the out-of-care placement process. A CBHA is intended to be completed approximately 30 days after the child enters out-of-home care; therefore, it may not be available when a child is first in need of a placement. A CBHA will be reimbursed once every state fiscal year for a child in out-of-home care.

⁶² Federal and state laws require that a child's placement must be the least restrictive setting possible to safeguard the physical and mental health and welfare of the child.

Exhibit D-1

Children Should Be Placed in the Least Restrictive Setting Possible

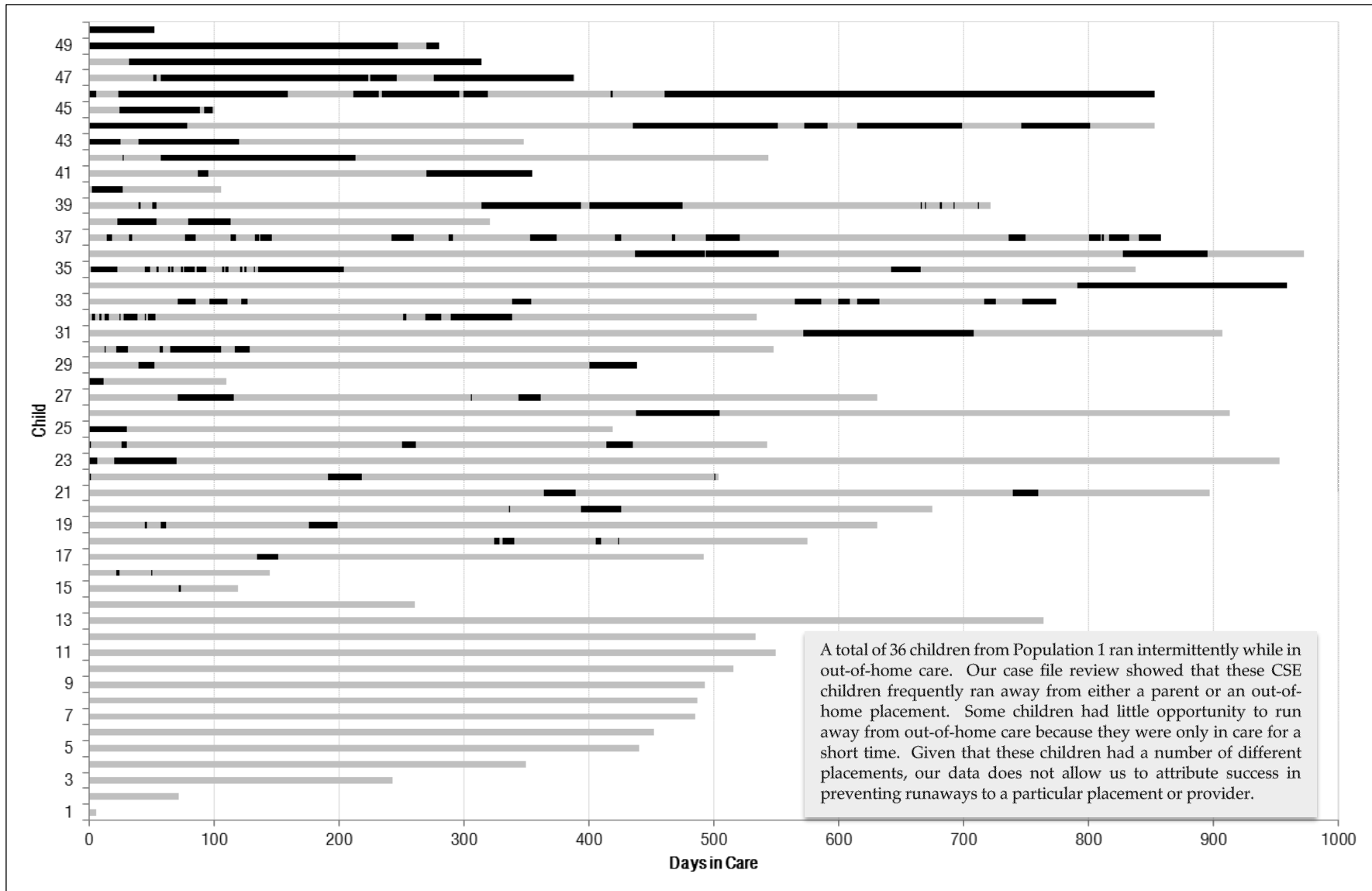


*Specialized service or track of services for CSE children.

Source: OPPAGA analysis of Florida statutes and rules, and the Florida Medicaid Specialized Therapeutic Services Coverage Limitations Handbook.

Appendix E

Timeline of Runaway (black) and Non-Runaway Episodes (gray) for CSE Children in Population 1 in Out-of-Home Care



Source: OPPAGA analysis of Department of Children and Families data.

Appendix F



**State of Florida
Department of Children and Families**

Rick Scott
Governor

Mike Carroll
Secretary

June 27, 2016

R. Philip Twogood, Coordinator
The Florida Legislature
Office of Program Policy Analysis
and Government Accountability
111 West Madison Street, Room 312
Tallahassee, FL 32399-1475

Dear Coordinator Twogood:

Thank you for sharing the preliminary findings and recommendations of OPPAGA's report:
*Placement Challenges Persist for Child Victims of Commercial Sexual Exploitation; Questions
Regarding Effective Interventions and Outcomes Remain.*

As requested, pursuant to s. 11.51(2), *Florida Statutes*, please find attached the department's
official response to this draft.

The department appreciates the responsiveness of Mary Alice Nye, who has worked closely with
the Office of Child Welfare in the preparation of this report.

If you have any questions or would like to discuss this response further, please contact JoShonda
Guerrier, Assistant Secretary for Child Welfare, at (850) 717-4159.

Sincerely,

A handwritten signature in blue ink, appearing to read "Mike Carroll", followed by the initials "F12".

Mike Carroll
Secretary

Attachment

cc: David L. Fairbanks, Deputy Secretary, Department of Children and Families
JoShonda Guerrier, Assistant Secretary for Child Welfare, Department of Children and
Families
Keith Parks, Inspector General, Department of Children and Families
Melinda Miguel, Chief Inspector General, Executive Office of the Governor

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

Mission: Work in Partnership with Local Communities to Protect the Vulnerable, Promote Strong and
Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency



State of Florida
Department of Children and Families

Rick Scott
Governor

Mike Carroll
Secretary

**DCF Response to OPPAGA Report:
“Placement Challenges Persist for Child Victims of Commercial
Sexual Exploitation; Questions Regarding Effective Interventions and
Outcomes Remain”**

Florida continues to receive national recognition as a leader in the fight against human trafficking and has provided technical assistance to other states looking to replicate its innovative approach to serving child victims of human trafficking. Although the state has made great strides, the Department remains committed to identifying effective interventions for CSE children and will continue its evaluation of existing treatment and services.

During the time period reviewed by The Florida Legislature Office of Program Policy Analysis & Government Accountability (OPPAGA), the Department continued its efforts to address human trafficking in Florida through the following actions:

- Certification of safe houses and safe foster homes; rule
- Implementation of the Human Trafficking Screening Tool
- Training and implementation statewide
- Creation of workgroups to focus on clinical response

Below are specific responses to each recommendation cited in the OPPAGA report.

OPPAGA Conclusions and Recommendations

- *DCF should gather systematic feedback from users about the screening instrument.*

Regions are reporting information on a monthly basis. We will request, in addition to the data collected now, that they provide any narrative feedback monthly. In addition, we will share feedback with the Florida Institute of Child Welfare, as they were instrumental in the screening criteria development.

1317 Winewood Boulevard, Tallahassee, Florida 32399-0700

Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

- *DCF and DJJ should validate the screening tool when sufficient data and support are available to do so.*

DJJ is working on validating the tool. This will officially occur when a large enough sample pool has been established. Continued implementation of the tool will result in the population size needed for validation. A request has been submitted to automate the tool in Florida's Safe Families Network (FSFN). The FSFN functionality team has reviewed the request and has assigned a priority level. Once the tool has been imbedded in FSFN, establishing validation can begin for DCF.

- *DCF should consider data representing the diverse needs and placements of the CSE population when working to identify relevant treatment outcomes.*

We have been collecting data, where available, since the inception of the Statewide Council on Human Trafficking through the Services and Resources committee. DCF will continue to research funding sources to support the independent, academic evaluation of treatment programs so that we have the necessary information to identify the needs of unique groups.



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

Rick Scott, Governor

Christina K. Daly, Secretary

June 21, 2016

Mr. R. Philip Twogood, Coordinator
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street
Tallahassee, Florida 32399-1475

Dear Mr. Twogood:

The Department has received and reviewed the preliminary findings and recommendations of OPPAGA's report titled *Placement Challenges Persist for Child Victims of Commercial Sexual Exploitation; Questions Regarding Effective Interventions and Outcomes Remain*. Please consider this letter the Department's official response to the preliminary Report, in accordance with subsection 11.51(2), Florida Statutes. The Department does not suggest modification to the Report with regard to the preliminary findings and recommendations relevant to the Department included therein.

A key goal of the agency is to increase identification of victims of human trafficking through staff training and youth screening and to connect victims to appropriate services. As the Report describes, DJJ has implemented an automated Human Trafficking Screening Tool to be used in all DJJ intake facilities and has worked to train staff to administer the tool using a victim-centered approach. The Department is proud to assist in screening efforts and serve as a safety net for children not previously identified as victims of human trafficking.

DJJ is committed to ongoing improvement of the tool and continuing our work to address this population of youth. Moreover, the Department is dedicated to further collection of data in hopes of future validation of the screening tool as you recommend and to better understand the scope of trafficking in Florida and the incidence of these youth within the delinquency system.

Thank you for the opportunity to review your preliminary findings and Report.

Sincerely,

Christina K. Daly
Secretary

cc: Mr. Robert Munson, Inspector General, Department of Juvenile Justice
Ms. Meredith Stanfield, Director of Legislative Affairs, Department of Juvenile Justice
Mr. Fred Schuknecht, Chief of Staff, Department of Juvenile Justice
Ms. Melinda Miguel, Chief Inspector General, Executive Office of the Governor

2737 Centerview Drive • Tallahassee, Florida 32399-3100 • (850) 488-1850
<http://www.djj.state.fl.us>

The mission of the Department of Juvenile Justice is to increase public safety by reducing juvenile delinquency through effective prevention, intervention, and treatment services that strengthen families and turn around the lives of troubled youth.